ArchPoint Pain Institute

Condensed Pain Evaluation Form - Follow-up Patients

PATIENT NAME:				DATE OF BIRTH:								
Where is your	pain (such a	as neck,	low bac	k, knee,	etc)?							
What medication												
What does this	medicatio	n(s) all	ow yo	u to do	that you	would n	ot be able	e to do o	otherwise	?		
Do you have a	ny side eff	ects w	ith you	ır curre	nt pain m	nedicatio	ns (such	as cons	stipation c	or nausea)?		
Do you take an Since your last family history c	office visi	t, have	your	medica	tions cha	anged; ha	ave you b	een ho	spitalized	; have you	had surgery;	
Vaccination a	nd Immu	nizatio	on stat	us: (ple	ease circ	le "Y" fo	or yes or '	'N" for	no)			
Pneumococcal:	: 1. Are ye	1. Are you currently up to date on this vaccinati						Υ /	N -If yes	s, please rec	ord the date	
	2. If not, do you intend on getting this vaccinati						ation?	Y /	N			
	3. Are ye	ou curr	ently (60 year	s of age	or older?		Υ /	N			
Influenza:	1. Are y	ou curi	ently	up to da	ate on the	is vaccin	ation?	Υ /	N -If yes	, please rec	ord the date	
COVID-19:	 Are you currently up to date on this vaccination Are you fully vaccinated for the COVID-19 via 										ord the date	
	2. If yes, have you received the COVID-19 boost									-		
	 2. If yes, have you received the COVID-19 booster? Y / N -Please record the date											
	3 If no t	n #1 (lo vou	intend	on getti	no this v	accinatio	$\mathbf{n} \land \mathbf{y} \downarrow$	N			
In case of an e			•		C	C				you design	ata as vour	decision
In case of an e	emergency	, if yo	u are	unable	to make	e a medi	cal decis	ion, wh	o would	you design	ate as your	decision
maker?:	emergency	y, if yo	u are	unable	to make	e a medi	cal decis	ion, wh	o would	you design	ate as your	decision
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